INTERNATIONAL STUDENTS PHYSICAL & IMMUNIZATION FORM

All international students (graduate and undergraduate) must complete and submit this form to Student Health.

Minor students must have a parent or guardian complete the form.

If attending in fall form is due July 31

If attending in spring form is due January 1

Incomplete or overdue forms can result in registration withdrawal and prevent sports participation.

Physical examinations must be done within 12 months of attendance. For intercollegiate Division 1 athletes, physical examinations must be done within 6 months for sports participation.

*Please note, date format Month/Day/Year (MM/DD/YY).

Mail form to: **STUDENT HEALTH CENTER**
2001 Main Street, Buffalo, NY 14208
Fax form to: 716.888.3217
Upload form to myCanisiusHealth
P: 716.888.2610

LAST NAME | FIRST NAME | MIDDLE INITIAL | COLLEGE ID / MEDICAT ID

☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YYYY) | GENDER | EMAIL ADDRESS

PERMANENT ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | CITIZENSHIP

EMERGENCY CONTACT - This is the person we will contact in the event you have a medical emergency at school.

EMERGENCY CONTACT - NAME/RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE

EMERGENCY CONTACT - ADDRESS | CITY | COUNTRY | POSTAL CODE | EMAIL ADDRESS

PERSONAL PHYSICIAN

PERSONAL PRIMARY PHYSICIAN | ADDRESS | PHONE | FAX

CONSENT TO TREAT, ATTESTATION, AUTHORIZATION FOR MYCANISIUSHEALTH PORTAL

Without signature Student Health can not treat this student. Parent or Guardian must sign for student under 18 years of age. I authorize the Canisius College Student Health Center to provide care and treatment to me (my child/legal ward) as deemed appropriate. This includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which the Student Health Center is aware, I authorize the Student Health Center or college designee to notify my emergency contact. I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Center hereafter of any changes in my health that occur while a student at Canisius College. I authorize Student Health to communicate with me using my secure health portal, myCanisiusHealth. This communication may include but is not limited to lab results, clinical notes and additional medical recommendations for my ongoing care and treatment each semester I am a registered student at the college. Access to myCanisiusHealth is limited to the current semester enrolled.

SIGNATURE OF STUDENT (REQUIRED) | **DATE (MM/DD/YY)**

SIGNATURE OF PARENT/GUARDIAN FOR MINOR (REQUIRED) | **DATE (MM/DD/YY)**

DO NOT WRITE BELOW THIS LINE

REVIEWED BY: Initials _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF COMMUNICABLE DISEASE CONTROL
MENINGOCOCCAL DISEASE

WHAT IS MENINGOCOCCAL DISEASE?
Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

WHO GETS MENINGOCOCCAL DISEASE?
Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:
- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings like college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris or, who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

WHAT ARE THE SYMPTOMS?
Symptoms appear suddenly-usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:
- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

HOW DOES MENINGOCOCCAL DISEASE SPREAD?
It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

WHAT ARE THE COMPLICATIONS?
Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:
- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

WHAT IS THE TREATMENT FOR MENINGOCOCCAL DISEASE?
Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

WHAT SHOULD I DO IF I OR SOMEONE I LOVE IS EXPOSED?
If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

WHAT IS THE BEST WAY TO PREVENT MENINGOCOCCAL DISEASE?
The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:
- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is at 11 to 12 years of age, and the second dose (booster) at age 16.
  - It is very important that students receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
  - Talk to your health care provider if you have not received two doses of vaccine against meningococcal strains A, C, W and Y.
- College students can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend the vaccine against the "B" strain.

Others who should receive the vaccine include:
- Infants, children and adults with certain medical conditions
- First-year college students through 21 years of age living in residential housing
- People exposed during an outbreak
- Travelers to the "meningitis belt" of Sub-Saharan Africa
- Military recruits

IS THERE AN INCREASED RISK FOR MENINGOCOCCAL DISEASE IF I TRAVEL?
Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic. To reduce your risk of illness, wash your hands often, maintain healthy habits, such as, getting plenty of rest and try not to come into contact with people who are sick.

HOW DO I GET MORE INFORMATION ABOUT MENINGOCOCCAL DISEASE AND VACCINATION?
Learn more about meningococcal disease at **www.cdc.gov/meningococcal/** or **www.health.ny.gov/.**

11/2016 | 542.1516

IMMUNIZATIONS

NEW YORK STATE LAW - Health care provider complete and sign the immunization section. Immunization records attached to this form must be signed or stamped. Please record all dates as Month/Day/Year

NAME OF STUDENT | DATE OF BIRTH (MM/DD/YYYY) | COLLEGE ID #

MMR (Measles, Mumps, Rubella)	If born after 1956, two doses of MMR vaccine required. **Dose #1** administered on or after the 1st birthday. **Dose #2** administered at least 28 days after the first dose.	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)		
MMR Serology/Titer	Laboratory confirmation of immunity. **(Laboratory report must be submitted with this form).**	Measles Titer Date ___ / ___ / ___ (MM / DD / YY) ☐ Immune ☐ Non Immune	Mumps Titer Date ___ / ___ / ___ (MM / DD / YY) ☐ Immune ☐ Non Immune	Rubella Titer Date ___ / ___ / ___ (MM / DD / YY) ☐ Immune ☐ Non Immune	
MENINGOCOCCAL QUADRIVALENT	One dose ACYW within past 5 years	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)		
MENINGOCOCCAL SEROGROUP B	Completed series of two or three doses within past 5 years	MenB-RC (Bexsero) Dose #1 ___ / ___ / ___ (MM / DD / YY)	MenB-RC (Bexsero) Dose #2 ___ / ___ / ___ (MM / DD / YY)	MenB-FHbp (Trumenba) Dose #1 ___ / ___ / ___ (MM / DD / YY)	MenB-FHbp (Trumenba) Dose #2 ___ / ___ / ___ (MM / DD / YY)
				MenB-FHbp (Trumenba) Dose #3 ___ / ___ / ___ (MM / DD / YY)	
VARICELLA VACCINE	Two doses, disease date or serology.	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)	Disease Date ___ / ___ / ___ (MM / DD / YY)	Serology Date ___ / ___ / ___ (MM / DD / YY) ☐ Immune
TETANUS, DIPTHERIA PERTUSSIS	One booster within last 10 years. A single dose of Tdap recommended for all students.	☐ Tdap ___ / ___ / ___ (MM / DD / YY)	☐ Td ___ / ___ / ___ (MM / DD / YY)		
POLIO VACCINE	Date primary series completed.	___ / ___ / ___ (MM / DD / YY)			
HEPATITIS B VACCINE	Series of 3 doses.	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)	Dose #3 ___ / ___ / ___ (MM / DD / YY)	
HEPATITIS A VACCINE	Series of 2 doses.	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)		
HPV	Two or Three doses based on 2016 ACIP guidelines	Dose #1 ___ / ___ / ___ (MM / DD / YY)	Dose #2 ___ / ___ / ___ (MM / DD / YY)	Dose #3 ___ / ___ / ___ (MM / DD / YY)	

HEALTH CARE PROVIDER SIGNATURE | **HEALTH CARE PROVIDER PRINTED NAME**

ADDRESS | **PHONE**

MENINGITIS RESPONSE: IMPORTANT – THIS RESPONSE IS REQUIRED BY NEW YORK STATE LAW FOR ALL STUDENTS IF NOT VACCINATED WITHIN THE PAST 5 YEARS.

☐ I have read or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain the immunization against meningococcal meningitis disease.

SIGNATURE OF STUDENT OR PARENT/GUARDIAN OF MINOR STUDENT | **DATE (MM/DD/YY)**

MEDICAL HISTORY

NAME OF STUDENT _____ DATE OF BIRTH (MM/DD/YYYY) _____ COLLEGE ID # _____

Please check box if you have ever had any of the following conditions.

INFECTIOUS DISEASE
- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Malaria

EYES, EARS, NOSE, THROAT
- ☐ Wear Glasses/Contact
- ☐ Other Visual Problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

CARDIOPULMONARY
- ☐ Chest Pain with Exercise or Exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive Exertional or Unexplained Shortness of Breath with Exercise
- ☐ Excessive Exertional or Unexplained Fatigue with Exercise
- ☐ Heart Murmur
- ☐ Elevated Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Elevated Cholesterol
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I
- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: _____
- ☐ Hernia
- ☐ Rectal Bleeding
- ☐ Irritable Bowel
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids

GENITOURINARY
- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Sexually Transmitted Infection

FEMALE
- ☐ Pelvic/Vaginal Infections
- ☐ Pregnancy
- ☐ Breast Lump
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Heavy Flow
- ☐ Abnormal PAP Smear

MALE
- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Undescended/Absent Testicle
- ☐ Hydrocele or Varicocele

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint Injury
- ☐ Bone Fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

HEMATOLOGIC/ONCOLOGIC
- ☐ Anemia
- ☐ Sickle Cell Trait/Disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency
- ☐ Cancer

NEUROLOGIC
- ☐ ADD/ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with Loss of Consciousness
- ☐ Other Neurological Disorders

SKIN
- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic Rash
- ☐ Tattoos/Piercings
- ☐ Other: _____

METABOLIC
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

MENTAL/EMOTIONAL
- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Trouble Sleeping
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate Self Harm
- ☐ Previous Psychiatric Hospitalization
- ☐ Other: _____

OTHER
- ☐ Anaphylactic Reaction
- ☐ Serious Accident/Injury
- ☐ Loss of Paired Organ:
  - ☐ Kidney
  - ☐ Ovary
  - ☐ Eye
  - ☐ Testicle
  - ☐ Other: _____
- ☐ Other Important Medical History: _____

Do you use tobacco?
☐ No ☐ Yes – packs/day _____

Do you drink alcohol?
☐ No ☐ Yes – amount/week _____

ALLERGIES: ☐ None
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/ environmental

Please list all:
_____
_____
_____

SURGERIES: ☐ None
- ☐ Appendectomy ☐ Hernia repair
- ☐ Mole Removal ☐ Ear Tubes
- ☐ Wisdom Teeth Extraction
- ☐ Tonsils/Adenoids
- ☐ Other: (specify below)

_____
_____
_____

MEDICATIONS (including vitamins and supplements):
☐ None
_____
_____
_____
_____
_____

Additional information you wish to share about your health:
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Age	If Deceased, State of Health	Age of Death	Cause of Death
Father				
Mother				
Siblings				

Have any of your relatives ever had any of the following?	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Asthma, Hay Fever			Mental Illness		
Diabetes			Kidney Disease		
Sickle Cell Trait/Disease			Seizure Disorder		
Disability due to heart disease before age 50			Marfan syndrome		
Elevated Blood Pressure			Other (list):		
Other heart related diagnosis, cardiomyopathies, long QT syndrome, arrhythmias					

PHYSICAL EXAMINATION

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER.

NAME | DATE OF BIRTH (MM/DD/YYYY) | ☐ MALE ☐ FEMALE GENDER

HEIGHT | WEIGHT | BLOOD PRESSURE | PULSE

DIVISION 1 ATHLETES SICKLE CELL SCREEN RECOMMENDED Sickle Cell Screen Date: MONTH ____ DAY ____ YEAR ____
☐ Positive ☐ Negative

TUBERCULOSIS (TB) SCREEN - Required for all students.

1. Does the student have signs or symptoms of active TB disease ☐ YES (go to TB Test) ☐ NO (go to question 2)
2. Is the student a member of a high risk group, or from a high risk country.
☐ YES (go to TB Test) ☐ NO (**STOP** No further screening needed)

TB SKIN TEST OR TB BLOOD TEST

TUBERCULIN SKIN TEST: (Mantoux only)
Date placed: ____/____/____ (MM/DD/YY) Date read: ____/____/____ (MM/DD/YY)
Result: ____mm of induration
Interpretation based on mm of induration and risk factors:
☐ Negative ☐ Positive (Chest X-ray required)

IGRA: (Specify method) ☐ QFT-G ☐ QFT-GIT ☐ T-SPOT
Date Tested: ____/____/____ (MM/DD/YY)
Result: ☐ Negative
☐ Indeterminate/Borderline (repeat in 6-8 weeks)
☐ Positive (Chest X-Ray required)

Chest X-Ray Date: ____/____/____ (MM/DD/YY) Result: ☐ Normal ☐ Abnormal (explain): _____
Treatment Plan (include information about INH therapy and duration of treatment): _____

CLINICAL EVALUATION	NORMAL	RECORD ABNORMAL FINDINGS
1. Appearance (Report evidence of Marfan Stigmata)		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing, Visual Acuity		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart (supine and standing)		
9. Pulses (simultaneous femoral and radial)		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurologic		
15. Emotional/Psychological		
16. Paired Organ Anatomy/Function		

17. **ACTIVITY CLEARANCE**
Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?
☐ **YES** - Full activity and fit for college ☐ **NO** - Limited activity Reason: _____

18. Additional Comments/Recommendations: _____

I have reviewed the medical history and immunizations, conducted the TB screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge.

HEALTH CARE PROVIDER SIGNATURE | **HEALTH CARE PROVIDER PRINTED NAME** | **DATE OF EXAM (MM/DD/YY)**

ADDRESS | **PHONE**